



Consent for Cooltouch Laser Treatments

Wrinkles, Stretch Marks, Scars

I authorize Surface Medical Spa personnel to perform Cooltouch laser treatments on me. I understand that this procedure is purely elective.

I understand that serious complications are rare but possible. Complications from treatments may include: pain, redness, itching, irritation, swelling, infection and failure to achieve the desired or expected result. In rare cases (less than 1%), patients have experienced crusting, blistering, scarring and pigment changes. I understand that I must not expose the treated area to the sun or sun lamps for at least one week to avoid skin damage. I have been informed and understand that protective eye wear must be worn at all times during treatments to avoid laser exposure to the eyes. By signing this consent I certify that I am not pregnant.

I understand a minimum of three (3) treatments every 2- 4 weeks are necessary to achieve results, which may improve for up to six (6) months or longer.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publication, promotional and sales purposes. These photographs may be used and displayed publicly without my permission. I understand full-face photographs revealing my identity will not be used without my written consent.

Pre and post treatment instructions have been discussed with me. The procedure, as well as potential benefits and risks have been explained to my satisfaction. I have had all of my questions answered and freely consent to the proposed treatments.

Patient Signature _____ Witness Signature _____

Print Name _____ Print Name _____

Date _____ Date _____